CODE	Section VIII CLAIMS PROCESSING Standard of 95 percent relates to requirements for which sampling is appropriate. Use Worksheet: WS-CP1 and WS-CP2
CP01	**The M+CO assumes financial responsibility and provides reasonable reimbursement for services obtained from a non-contracting provider: ambulance services dispatched through 911, emergency services, urgently needed services, post stabilization care as well as temporarily out of area renal dialysis services that Medicare enrollees obtain even without prior authorization.** **42CFR422.100 (b)(1)** **[ ] MET [ ] NOT MET[ ] NOTE**
CP02	**The M+CO pays 95 percent of "clean" claims from unaffiliated providers within 30-days of receipt and provides payment in the amount the provider has billed, with maximum required payment to the provider being the amount the provider would have received under Original Medicare (including balance billing permitted under Medicare Part A and Part B). Payment of a clean claim constitutes an organizational determination. When clean claims are paid in over 30 days, interest is computed and paid.** **~~Appropriation Bill, October 1992, O.P.L. 102-394;~~ 1842(c)(2) and 1816(c)(2) of the Social Security Act, ~~and Section 9311 of OBRA 1986.~~** **42CFR422.100(b)(2), 42 CFR422.500, 42CFR422.520(a)(1)&(2), 42CFR 422.568(b)** **[ ] MET [ ] NOT MET[ ] NOTE**
CP02A ~~New Element~~	**If the M+CO delegates claims processing to contracting medical groups, IPAs, or other entities, these entities pay 95 percent of clean claims within 30 days of receipt from unaffiliated providers and provides payment to the provider in the amount the provider has billed, with maximum required payment to the provider being the amount original Medicare would have paid (including balance billing permitted under Medicare Part A and Part B). When clean claims are paid over 30 days, interest is computed and paid. The M+CO maintains ultimate responsibility for adhering to and otherwise fully complying with the terms and conditions of its contract with HCFA.** **~~Appropriation Bill, October 1992, P.L. 102-394~~; 1842(c)(2) and 1816(c)(2) of the Social Security Act, ~~and Section 9311 of OBRA 1986~~. 42CFR422.100(b)(2), 42 CFR422.500, 42CFR422.520(a)(1)&(2)** **[ ] NOT APPLICABLE [ ] MET [ ] NOT MET[ ] NOTE**
MOE CP01-02A	• Determine if the M+CO/delegated entity makes accurate determinations of emergency, urgently needed services, covered benefits, and clean/non-clean claims so that they are appropriately processed. *Social Security Act*, § 1842(c)(2)(B) and § 1816(c)(2)(B) • Are M+COs/delegated entities paying the claims for out of area renal dialysis, and post stabilization care? • Are M+COs/delegated entities addressing balanced billing issues with providers? (Balance billing refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer will pay for the service, plus any cost sharing by the individual.) (**Definition**: A "*clean*" claim is a claim that has no defect or impropriety, including lack of required substantiating documentation (consistent with 422.257(d)) ~~for non-contracting providers and suppliers~~, or particular circumstances requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare ~~from being made on the claim~~. (§1842(c)(2)(B)) of the *Social Security Act* and 42CFR 422.500. Per 422.257(d), claims with inadequate coding or other deficiencies in encounter data requirements are not clean claims. A claim is clean even though the M+CO refers it to a medical specialist within the M+CO for examination. If additional substantiating documentation (e.g., the medical record, encounter data) involves a source outside the M+CO, the claim is not considered "clean.") • If payment is not made on a clean claim from an unaffiliated provider within 30 days, interest should be paid at the rate used for purposes of section 3902(a) of Title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required

	payment date and ending on the date on which payment is made. The rate is approved by the Secretary of the Treasury and is published in the *Federal Register* twice each year. Interest must be paid on the total amount due on the claim defined as the amount the provider has billed, with maximum required payment to the provider being the amount the provider would have received under Original Medicare (including balance billing permitted under Medicare Part A and Part B).
CP03 ~~**New Element**~~	**Contracts and other written agreements between M+CO and providers must contain a prompt payment provision. The payment terms of these contracts are agreed upon by the M+CO and relevant providers.** **422.520(b), 522.510(a)(9), OPL 99.77** **Cross refere~~nce~~ findings with ~~HSD contracting elements and~~ AM10 ~~contract review requirements.~~** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE CP03	Determine if the contracts between the M+CO and affiliated providers/suppliers contain prompt payment provisions.
CP04	**The M+CO makes an organization determination within 60 calendar days from receipt of all other claims. If the M+CO makes a determination that is wholly or only partially adverse to the enrollee, it notifies the enrollee of its determination (denial) within 60 calendar days from receipt of the claim. HCFA considers organization determinations timely when 95 % clean claims are paid within 30 days and all other claims are approved or denied within 60 calendar days from the date of receipt.** **42CFR422.520(a)** **CFR422.520(a)** **CFR422.520(a)[ ] MET** **[ ] NOT MET[ ] NOTE**
CP04A ~~**New Element**~~	**If the M+CO delegates making and processing organization determinations to contracted medical groups, IPAs, or another entity, the determinations must be made within 60 calendar days from receipt of claims If the M+CO delegates making a determination that is wholly or only partially adverse to the enrollee, the delegated entity must notify the enrollee of the determination (denial) within 60 calendar days from receipt of the claim. HCFA considers organization determinations timely when 95 % clean claims are paid within 30 days and all other claims are approved or denied within 60 calendar days from the date of receipt. The M+CO maintains ultimate responsibility for adhering to and otherwise fully complying with the terms and conditions of its contract with HCFA.** **42CFR422.520(a)** **[ ] NOT APPLICABLE [ ] MET [ ] NOT MET[ ] NOTE**
CP05	**The M+CO must provide the enrollee of the right to appeal if it has failed to make a determination (adverse) within 60 calendar days of receipt of the claim (i.e., failure to provide notice is deemed an adverse organization determination subject to appeal). 42CFR422.562(b), 42CFR422.568(e)** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE CP04-CP05	Determine whether the M+CO and/or its contracting providers control processes and pay/deny claims consistent with statutory requirements (30 and 60 calendar day standards). Assess the adequacy of the M+CO's claims processing system. It should identify and track all claims and include the following types of

	information: • provider and amount billed; • date the claim was received; • date additional development was initiated; • date claim was adjudicated; • amount paid; • date check written and mailed; • reason for denial, if applicable; • procedures for claims transferred from a carrier or fiscal intermediary (they should be treated like any other incoming claim). **Procedures should specify time frames for:** • making determination of "clean" or "non-clean" within specific number of days of receipt; • initiating development of non-clean claims within a specific number of days; • following-up up on pending claims within a specific number of days of original request for additional information with subsequent requests at specified intervals; • making an organization determination to pay or deny.
MOE CP04-CP05 Cont.	**Review/ Determine:** • M+CO's oversight of its contracting groups. Are its providers aware of claims processing requirements? Are the M+CO's claims processing procedures written and available to staff? • The M+CO and/or its contracting providers correctly identify "clean" claims. • M+CO's written instructions to ensure that the definition of "clean" claims is consistent with HCFA's definition. ~~and a sample of paid claims from unaffiliated providers to determine processing times.~~ • The M+CO and/or its contracting providers accurately process claims for covered services, including ambulance services dispatched through 911 emergency and urgently needed services, post stabilization care as well as temporarily out of area renal dialysis services and point-of-service (POS) related claims. • M+CO's written instructions to ensure the definitions of emergency, urgently needed and post stabilization care as well as temporarily out of area renal dialysis services are consistent with the regulations (e.g., no prior authorization is required). • Claim denials to ensure that Medicare covered services and other benefits outlined in the M+CO's evidence of coverage (EOC) (including services delivered pursuant to any POS benefit) are not inappropriately denied. • Claims to ensure that authorized services are considered M+CO services, subject only to member cost sharing outlined in the subscriber agreement and ACR. • Processed claims to ensure that only appropriate co-payments are billed to the enrollee. • If the M+CO offers a point-of-service (POS) benefit, review the M+CO's written procedures for ~~assuring~~ ensuring that proper coverage decisions and appropriate payments are made for non-contracted providers and suppliers providing services by way of the M+CO's POS benefit. Review any claims processing procedures specific to processing POS claims. In making determinations, include an assessment of the M+CO's contracting providers (to ensure covered services are provided by IPA/medical

	group's network of specialists and other health care providers). Is the oversight adequate so that the M+CO/contracting providers meet the requirements? Coordinate the claims review with the Appeals review in Section ~~XII~~ IX to determine whether the M+CO meets the ~~30/60 calendar day~~ time frame~~s~~ for notifying the enrollee of adverse organization determinations. (See CFR 422.568(b).) (NOTE: Interest payments are only required on clean claims.) (NOTE: Some States have claims processing time frames that M+CO's are expected to meet. It is helpful to know what the State's requirements are and whether the State monitors the M+CO based on these requirements.)

CPO6 ~~New Element~~	**The M+CO must have the capacity to communicate with HCFA electronically. The M+CO must submit to HCFA, in accordance with HCFA instructions, all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.** **42CFR422.257, 42CFR422.502(b), OPL 98.70 CROSSWALK TO AM08** **[ ] MET [ ] NOT MET[ ] NOTE**
MOE CP06	~~Types of service and timing of submittal of encounter data:~~ ~~● Inpatient hospital care data, requirement on and after 7/1/1997, and~~ ~~● Physician data, beginning 10/1/2000~~ ~~● outpatient hospital, SNF, and HHA data, requirement no earlier than 10/1/2000, and~~ ~~● All other data HCFA deems necessary, requirement no earlier than 10/1/2000~~ ~~Other required electonic data:~~ ~~● Electronic submission of ACRs~~ To the extent required by HCFA, the data must account for services covered under the original Medicare program, ~~for~~ Medicare covered services for which Medicare is not the primary payor, or ~~for~~ other additional or supplemental benefits that the M+CO may provide. The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the Medicare fee-for-service program, ~~even~~ if ~~they~~ more than one provider participate~~s jointly~~ in the ~~same~~ encounter. The data must conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards, and be submitted electronically to the appropriate HCFA contractor.
CP07	**The M+CO has procedures to identify payers which are primary to Medicare, determine the amounts payable, and coordinate benefits.** **42CFR422.108** **[ ] MET [ ] NOT MET[ ] NOTE**

MOE CP07	Determine whether the M+CO has written procedures to ensure that claims involving coordination of benefits (State or Federal workers compensation, EGHP, automobile medical, no-fault insurance, other liability, and self-insured ~~M+CO~~ plan) are identified. **REVIEW:** Procedures to determine: Who processes secondary payer issues. How secondary payer issues are identified. How identified cases are communicated to the department that processes these cases. Whether the M+CO's system flags claims when Medicare is secondary. ~~If recoveries are accounted for in the ACR calculation.~~ **Interview:** M+CO Coordination of Benefits (COB) and financial staff.